		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042697

Facility Name: SunBridge Care & Rehab-University

Address: 1095 University Drive (Number) Edwardsville (City) 62025 (Zip Code)

County: Madison

Telephone Number: (618) 656-1081 **Fax #** (618) 656-7083

IDPA ID Number: 850370802-039

Date of Initial License for Current Owners: 6/1/97

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Robert Rael **Telephone Number:** (505) 468-2467

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ 3/30/01 (Date)
(Type or Print Name) Dean Kiklis
(Title) VP of Reimbursement

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) _____
(Firm Name & Address) _____
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number SunBridge Care & Rehab-University # 0042697 Report Period Beginning: 1/1/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds: No bed changes

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	122	Skilled (SNF)	122	44,652	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	122	TOTALS	122	44,652	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	30,990	4,061	976	36,027	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,990	4,061	976	36,027	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.68%

D. How many bed-hold days during this year were paid by Public Aid? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 6/1/97

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 6/1/97 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 32 and days of care provided 182

Medicare Intermediary Trail Blazer Health Enterprises, LLC

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number SunBridge Care & Rehab-University # 0042697 Report Period Beginning: 1/1/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	115,088	10,233	8,364	133,685	29,871	163,556	(1,683)	161,873			1
2	Food Purchase		131,582		131,582		131,582	(73)	131,509			2
3	Housekeeping	(1,401)	2,936	95,311	96,846	1,401	98,247		98,247			3
4	Laundry	(891)	10,445	63,541	73,095	891	73,986		73,986			4
5	Heat and Other Utilities			109,654	109,654		109,654	706	110,360			5
6	Maintenance	26,694	5,457	36,701	68,852	1,752	70,604	376	70,980			6
7	Other (specify):*											7
8	**TOTAL General Services**	139,490	160,653	313,571	613,714	33,915	647,629	(674)	646,955			8
	B. Health Care and Programs											
9	Medical Director			8,100	8,100		8,100		8,100			9
10	Nursing and Medical Records	1,142,168	155,334	18,352	1,315,854	103,587	1,419,441		1,419,441			10
10a	Therapy		17,402	50,142	67,544		67,544		67,544			10a
11	Activities	31,668	3,421	30	35,119	2,078	37,197		37,197			11
12	Social Services	36,316		4,905	41,221	2,383	43,604		43,604			12
13	Nurse Aide Training											13
14	Program Transportation							11	11			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,210,152	176,157	81,529	1,467,838	108,048	1,575,886	11	1,575,897			16
	C. General Administration											
17	Administrative	61,686		181,250	242,936	(65,711)	177,225	(94,269)	82,956			17
18	Directors Fees											18
19	Professional Services			26,368	26,368	57	26,425	(16,209)	10,216			19
20	Dues, Fees, Subscriptions & Promotions			16,655	16,655	320	16,975	(121)	16,854			20
21	Clerical & General Office Expenses	104,554	11,824	38,029	154,407	14,868	169,275	57,067	226,342			21
22	Employee Benefits & Payroll Taxes			441,313	441,313	(99,483)	341,830	265,058	606,888			22
23	Inservice Training & Education			2,843	2,843	149	2,992		2,992			23
24	Travel and Seminar			5,736	5,736	7,830	13,566	3,776	17,342			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			47,496	47,496		47,496	(26,356)	21,140			26
27	Other (specify):*			28,327	28,327		28,327	(23,127)	5,200			27
28	**TOTAL General Administration**	166,240	11,824	788,017	966,081	(141,970)	824,111	165,819	989,930			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,515,882	348,634	1,183,117	3,047,633	(7)	3,047,626	165,156	3,212,782			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number SunBridge Care & Rehab-University #0042697 Report Period Beginning: 1/1/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			15,123	15,123		15,123	20,900	36,023			30
31	Amortization of Pre-Op. & Org.			3,226	3,226		3,226	3,247	6,473			31
32	Interest			340,643	340,643		340,643	(315,795)	24,848			32
33	Real Estate Taxes			50,423	50,423		50,423	331	50,754			33
34	Rent-Facility & Grounds			220,119	220,119	7	220,126	2,339	222,465			34
35	Rent-Equipment & Vehicles			15,903	15,903		15,903	3,440	19,343			35
36	Other (specify):*			554	554		554	7,410	7,964			36
37	**TOTAL Ownership**			645,991	645,991	7	645,998	(278,128)	367,870			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops							(1,510)	(1,510)			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			75,978	75,978		75,978		75,978			42
43	Other (specify):*			1,029	1,029		1,029		1,029			43
44	**TOTAL Special Cost Centers**			77,007	77,007		77,007	(1,510)	75,497			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,515,882	348,634	1,906,115	3,770,631		3,770,631	(114,482)	3,656,149			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number SunBridge Care & Rehab-University # 0042697 Report Period Beginning: 1/1/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(962)	1		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(73)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(26,084)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(19,742)	27		24
25	Fund Raising, Advertising and Promotional	(1,324)	27		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(93,141)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (141,326)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	26,844	SCH VII	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 26,844		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (114,482)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

SunBridge Care & Rehab-University

ID# 0042697

Report Period Beginning: 1/1/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Employee Meals	$		1
2	Rental Income			2
3	Personal Laundry Income			3
4	Rebates & Refunds			4
5	Sales Tax on food			5
6	Interest expense			6
7	Penalties and Late Fees			7
8	Contributions			8
9	Legal Services (Collection Fees)			9
10	Bad Debt Expense			10
11	Public Relations			11
12	Vending Machine Commission	(721)	1	12
13	Adjust Physical Therapy cost to actual		10a	13
14	Management Fee Expense (IC00)		17	14
15	Chamber of Commerce		20	15
16	Regional Public Relations	(320)	20	16
17	Royalty Fees (IC00)		20	17
18	Other Non-Oper Inc		21	18
19	Regional Marketing Director	(13,565)	21	19
20	Expense Minor Durable Equipment		10	20
21	Expense Minor Durable Equipment		06	21
22	Franchise\Intangible T		21	22
23	Expense Minor Durable Equipment			23
24	Resident Expenses	(2,061)	27	24
25	Adj LHI Depr Expense to actual	11,659	30	25
26	Adj equipment Depr Expense to actual	9,241	30	26
27	Depr Exp Minor Durable Equipment		30	27
28	Barber\Beauty Inc.	(1,510)	40	28
29	Patient Personal Services		21	29
30	Pat Personal Svcs Inc		21	30
31	Incontttinency Income		10	31
32	Equip Rental Income		35	32
33	Community Awareness		20	33
34	Special Events		20	34
35	Miscellaneous Exp (IC00)		27	35
36	Depr - Equipment (IC00)		27	36
37	Interest Expense - Interco (IC00)	(322,364)	32	37
38	FAS 121 Charge		21	38
39	Interest Expense - Net Assets		32	39
40	PTO Accrual Adjustment	(16,188)	22	40
41	Health Insurance Adjustment	312,165	22	41
42	Worker's Compensation Audit Adjustment		22	42
43	Worker's Compensation Adjustment	(38,513)	22	43
44	Professional & General Liability Insurance Adjustment	(27,969)	26	44
45	Property Insurance Adjustment	27	26	45
46	Auto Insurance Adjustment		26	46
47	Other Employee Amenities	721	21	47
48	Franchise/Intang. Tax	(517)	21	48
49	Amortize Goodwill	(3,226)	31	49
50				50
51				51
52				52
53				53
54				54
55				55
56				56
57				57
58				58
59				59
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73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	(93,141)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SunBridge Care & Rehab-University # 0042697 Report Period Beginning: 1/1/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(1,683)	0	0	0	0	0	0	0	0	0	0	(1,683)	1
2	Food Purchase	(73)	0	0	0	0	0	0	0	0	0	0	(73)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	706	0	0	0	0	0	0	0	0	0	706	5
6	Maintenance	0	376	0	0	0	0	0	0	0	0	0	376	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,756)	1,082	0	0	0	0	0	0	0	0	0	(674)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	11	0	0	0	0	0	0	0	0	0	11	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	11	0	0	0	0	0	0	0	0	0	11	16
	C. General Administration													
17	Administrative	0	(94,269)	0	0	0	0	0	0	0	0	0	(94,269)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(26,084)	9,875	0	0	0	0	0	0	0	0	0	(16,209)	19
20	Fees, Subscriptions & Promotions	(320)	199	0	0	0	0	0	0	0	0	0	(121)	20
21	Clerical & General Office Expenses	(13,361)	70,428	0	0	0	0	0	0	0	0	0	57,067	21
22	Employee Benefits & Payroll Taxes	257,464	7,594	0	0	0	0	0	0	0	0	0	265,058	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	3,776	0	0	0	0	0	0	0	0	0	3,776	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(27,942)	1,586	0	0	0	0	0	0	0	0	0	(26,356)	26
27	Other (specify):*	(23,127)	0	0	0	0	0	0	0	0	0	0	(23,127)	27
28	**TOTAL General Administration**	166,630	(811)	0	0	0	0	0	0	0	0	0	165,819	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	164,874	282	0	0	0	0	0	0	0	0	0	165,156	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **SunBridge Care & Rehab-University** **# 0042697** **Report Period Beginning:** **1/1/00** **Ending:** **12/31/00**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	20,900	0	0	0	0	0	0	0	0	0	0	20,900	30
31	Amortization of Pre-Op. & Org.	(3,226)	6,473	0	0	0	0	0	0	0	0	0	3,247	31
32	Interest	(322,364)	0	6,569	0	0	0	0	0	0	0	0	(315,795)	32
33	Real Estate Taxes	0	0	331	0	0	0	0	0	0	0	0	331	33
34	Rent-Facility & Grounds	0	0	2,339	0	0	0	0	0	0	0	0	2,339	34
35	Rent-Equipment & Vehicles	0	0	3,440	0	0	0	0	0	0	0	0	3,440	35
36	Other (specify):*	0	7,410	0	0	0	0	0	0	0	0	0	7,410	36
37	**TOTAL Ownership**	(304,690)	13,883	12,679	0	0	0	0	0	0	0	0	(278,128)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	(1,510)	0	0	0	0	0	0	0	0	0	0	(1,510)	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(1,510)	0	0	0	0	0	0	0	0	0	0	(1,510)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(141,326)	14,165	12,679	0	0	0	0	0	0	0	0	(114,482)	45

Facility Name & ID Number SunBridge Care & Rehab-University # 0042697 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SunBridge Healthcare Corp.	100%	Please see attached	Please see attached	Please see attached	Please see attached 6A	Please see attached
				6A		6A

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Heat and Other Utilities	$	SunBridge Healthcare Corporation	100.00%	$ 706	$ 706	1
2	V	6	Maintenance		SunBridge Healthcare Corporation	100.00%	376	376	2
3	V	14	Program Transportation		SunBridge Healthcare Corporation	100.00%	11	11	3
4	V	17	Administration	97,928	SunBridge Healthcare Corporation	100.00%	3,659	(94,269)	4
5	V	19	Legal and Accounting		SunBridge Healthcare Corporation	100.00%	9,875	9,875	5
6	V	20	Dues & Subscriptions		SunBridge Healthcare Corporation	100.00%	199	199	6
7	V	21	Clerical & General Offices Exp		SunBridge Healthcare Corporation	100.00%	70,428	70,428	7
8	V	22	Employee Benefits		SunBridge Healthcare Corporation	100.00%	7,594	7,594	8
9	V	24	Travel		SunBridge Healthcare Corporation	100.00%	3,776	3,776	9
10	V	26	Insurance		SunBridge Healthcare Corporation	100.00%	1,586	1,586	10
11	V	31	Amortization		SunBridge Healthcare Corporation	100.00%	6,473	6,473	11
12	V	36	Depreciation		SunBridge Healthcare Corporation	100.00%	7,410	7,410	12
13	V								13
14	Total			$ 97,928			$ 112,093	$ * 14,165	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SunBridge Care & Rehab-University # 0042697 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	32	Interest	$	SunBridge Healthcare Corporation	100.00%	$ 6,569	$ 6,569	15
16	V	33	Property Taxes		SunBridge Healthcare Corporation	100.00%	331	331	16
17	V	34	Facility Lease		SunBridge Healthcare Corporation	100.00%	2,339	2,339	17
18	V	35	Equipment Lease		SunBridge Healthcare Corporation	100.00%	3,440	3,440	18
19	V	39	Pharmacy Expense	43,527	Sunscript Pharmacy Corporation	100.00%	43,527		19
20	V	101	Physical,Speech,Occupational Ther	40,420	Sundance Rehabilitation Corporation	100.00%	40,420		20
21	V	101	Respiratory Therapy	49,514	Suncare Respiratory	100.00%	49,514		21
22	V	101	Medical Supplies & Equipment Rental	73,779	Sunchoice Medical Supply	100.00%	73,779		22
23	V	101	Software	2,891	Sunsystems	70.40%	2,891		23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 210,131			$ 222,810	$ * 12,679	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SunBridge Care & Rehab-University # 0042697 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Andrew L. Turner	CEO - Chairman of	Operations		534,652	0.057	0.00	Wages	$ 761	17.3	1
2		the Board									2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 761		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number SunBridge Care & Rehab-University # 0042697 Report Period Beginning: 1/1/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Sun Healthcare Group Inc. (Corporate)
Street Address: 101 Sun Avenue NE
City / State / Zip Code: Albuquerque, NM 87109
Phone Number: (505) 821-3355
Fax Number: (505) 856-2470

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Administrative	Accumulated Cost	##########	375	$ 1,894,390	$ 1,894,390	3,350,338	$ 3,636	1
2	5	Heat and Other Utilities	Accumulated Cost	##########	375	341,493		3,350,338	655	2
3	6	Maintenance	Accumulated Cost	##########	375	188,721		3,350,338	362	3
4	14	Program Transportation	Accumulated Cost	##########	375	5,653		3,350,338	11	4
5	19	Legal & Accounting	Accumulated Cost	##########	375	5,096,426		3,350,338	9,782	5
6	20	Dues and Subscriptions	Accumulated Cost	##########	375	97,795		3,350,338	188	6
7	21	General Office Expenses	Accumulated Cost	##########	375	28,601,481	20,782,087	3,350,338	54,896	7
8	22	Employee Benefits	Accumulated Cost	##########	375	3,197,917		3,350,338	6,138	8
9	24	Travel	Accumulated Cost	##########	375	1,138,452		3,350,338	2,185	9
10	26	Insurance	Accumulated Cost	##########	375	821,156		3,350,338	1,576	10
11	30	Depreciation	Accumulated Cost	##########	375	3,836,905		3,350,338	7,364	11
12	31	Amortization	Accumulated Cost	##########	375	3,351,056		3,350,338	6,432	12
13	32	Interest	Accumulated Cost	##########	375	3,401,102		3,350,338	6,528	13
14	33	Property Taxes	Accumulated Cost	##########	375	163,687		3,350,338	314	14
15	34	Facility Lease	Accumulated Cost	##########	375	852,135		3,350,338	1,636	15
16	35	Equipment Lease	Accumulated Cost	##########	375	1,612,216		3,350,338	3,094	16
17										17
18		Total from attached Page 8a	Accumulated Cost	379,321,017	111	1,357,473	931,879	3,350,338	11,990	18
19		Total from attached Page 8b	Accumulated Cost	195,229,250	54	465,269	215,903	3,350,338	7,985	19
20		Total from attached Page 8c	Direct Cost							20
21										21
22			*Total Units =							22
23			1,745,570,676							23
24										24
25	TOTALS					$ 56,423,327	$ 23,824,259		$ 124,772	25

Facility Name & ID Number SunBridge Care & Rehab-University # 0042697 Report Period Beginning: 1/1/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Sun Healthcare Group Inc. (Corporate)
Street Address: 101 Sun Avenue NE
City / State / Zip Code: Albuquerque, NM 87109
Phone Number: (505) 821-3355
Fax Number: (505) 856-2470

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Administrative	Accumulated Cost	379,321,017	111	$ 1,591	$ 1,591	3,350,338	$ 14	1
2	5	Heat and Other Utilities	Accumulated Cost	379,321,017	111	285		3,350,338	3	2
3	6	Maintenance	Accumulated Cost	379,321,017	111	576		3,350,338	5	3
4	14	Program Transportation	Accumulated Cost	379,321,017	111	4		3,350,338		4
5	19	Legal & Accounting	Accumulated Cost	379,321,017	111	3,367		3,350,338	30	5
6	20	Dues and Subscriptions	Accumulated Cost	379,321,017	111	217		3,350,338	2	6
7	21	General Office Expenses	Accumulated Cost	379,321,017	111	1,130,721	930,288	3,350,338	9,987	7
8	22	Employee Benefits	Accumulated Cost	379,321,017	111	118,303		3,350,338	1,045	8
9	24	Travel	Accumulated Cost	379,321,017	111	65,899		3,350,338	582	9
10	26	Insurance	Accumulated Cost	379,321,017	111	690		3,350,338	6	10
11	30	Depreciation	Accumulated Cost	379,321,017	111	3,222		3,350,338	28	11
12	31	Amortization	Accumulated Cost	379,321,017	111	2,814		3,350,338	25	12
13	32	Interest	Accumulated Cost	379,321,017	111	2,856		3,350,338	25	13
14	33	Property Taxes	Accumulated Cost	379,321,017	111	1,770		3,350,338	16	14
15	34	Facility Lease	Accumulated Cost	379,321,017	111	21,567		3,350,338	190	15
16	35	Equipment Lease	Accumulated Cost	379,321,017	111	3,591		3,350,338	32	16
17										17
18										18
19			*Total Units =							19
20			379,321,017							20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,357,473	$ 931,879		$ 11,990	25

Facility Name & ID Number SunBridge Care & Rehab-University # 0042697 Report Period Beginning: 1/1/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Sun Healthcare Group Inc. (Corporate)
Street Address: 101 Sun Avenue NE
City / State / Zip Code: Albuquerque, NM 87109
Phone Number: (505) 821-3355
Fax Number: (505) 856-2470

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Administrative	Accumulated Cost	195,229,250	54	$ 520	$ 520	3,350,338	$ 9	1
2	5	Heat and Other Utilities	Accumulated Cost	195,229,250	54	2,784		3,350,338	48	2
3	6	Maintenance	Accumulated Cost	195,229,250	54	501		3,350,338	9	3
4	14	Program Transportation	Accumulated Cost	195,229,250	54	1		3,350,338		4
5	19	Legal & Accounting	Accumulated Cost	195,229,250	54	3,666		3,350,338	63	5
6	20	Dues and Subscriptions	Accumulated Cost	195,229,250	54	508		3,350,338	9	6
7	21	General Office Expenses	Accumulated Cost	195,229,250	54	323,115	215,383	3,350,338	5,545	7
8	22	Employee Benefits	Accumulated Cost	195,229,250	54	23,964		3,350,338	411	8
9	24	Travel	Accumulated Cost	195,229,250	54	58,819		3,350,338	1,009	9
10	26	Insurance	Accumulated Cost	195,229,250	54	226		3,350,338	4	10
11	30	Depreciation	Accumulated Cost	195,229,250	54	1,055		3,350,338	18	11
12	31	Amortization	Accumulated Cost	195,229,250	54	921		3,350,338	16	12
13	32	Interest	Accumulated Cost	195,229,250	54	935		3,350,338	16	13
14	33	Property Taxes	Accumulated Cost	195,229,250	54	45		3,350,338	1	14
15	34	Facility Lease	Accumulated Cost	195,229,250	54	29,899		3,350,338	513	15
16	35	Equipment Lease	Accumulated Cost	195,229,250	54	18,310		3,350,338	314	16
17										17
18										18
19			*Total Units =							19
20			195,229,250							20
21										21
22										22
23										23
24										24
25	TOTALS					$ 465,269	$ 215,903		$ 7,985	25

Facility Name & ID Number SunBridge Care & Rehab-University # 0042697 Report Period Beginning: 1/1/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number SunBridge Care & Rehab-University # 0042697 Report Period Beginning: 1/1/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	43,328	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	43,771	2
3. Under or (over) accrual (line 2 minus line 1).	$	443	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	50,423	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	50,866	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	45,288	8
	1996	9,098	9
	1997	41,660	10
	1998	43,034	11
	1999	43,771	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number SunBridge Care & Rehab-University # 0042697 Report Period Beginning: 1/1/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,290 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 24,989
2. Number of Years Over Which it is Being Amortized: 7
3. Current Period Amortization: 3,226
4. Dates Incurred: 6/1/97

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number SunBridge Care & Rehab-University # 0042697 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12				1991							12
13	TOTALS FROM DEPRECIATION SCHEDULE			2000	217,382	19,707	Various	19,707		49,145	13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 217,382	$ 19,707		$ 19,707	$	$ 49,145	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SunBridge Care & Rehab-University # 0042697 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 127,979	$ 15,655	$ 15,655	$		$ 39,943	37
38	Current Year Purchases	5,445	661	661			661	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	$ 133,424	$ 16,316	$ 16,316	$		$ 40,604	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 350,806	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 36,023	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 36,023	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 89,749	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number SunBridge Care & Rehab-University # 0042697 Report Period Beginning: 1/1/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1978	122	6/1/97	$ 220,119	14	14	3
4	Additions							4
5								5
6								6
7	TOTAL		122		$ 220,119 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 6/1/1997
Ending 5/31/2011

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/2001	$ 222,601
13.	12/31/2002	$ 228,558
14.	12/31/2003	$ 234,674

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 16,086 Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number SunBridge Care & Rehab-University # 0042697 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	Line 10a Col 3	hrs	$	446	$ 15,203	$ 487	446	$ 15,690	1
2	Licensed Speech and Language Development Therapist	Line 10a Col 3	hrs		281	11,340	703	281	12,043	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	Line 10a Col 3	hrs		648	21,246	470	648	21,716	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	Line 10.2 Col 3	# of prescrpts				35,879		35,879	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Respiratory Therapy & Other (specify): IV Therapy	Line 10a Col 3			51	2,352	15,742	51	18,094	13
14	TOTAL			$	1,426	$ 50,141	$ 53,281	1,426	$ 103,422	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number SunBridge Care & Rehab-University # 0042697 **Report Period Beginning:** 1/1/00 **Ending:** 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 14,056	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	227,456		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	86		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 241,598	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	217,382		15
16	Equipment, at Historical Cost	133,423		16
17	Accumulated Depreciation (book methods)	(89,749)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	25,204		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(28,474)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 257,786	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 499,384	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ (63,440)	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	(116,573)		30
31	Accrued Taxes Payable (excluding real estate taxes)	358,271		31
32	Accrued Real Estate Taxes(Sch.IX-B)	(51,837)		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Please see attached Page 17.1	(71,106)		36
37	Business Tax Payable	(2,379)		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 52,936	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Inter Company Account	(3,028,623)		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ (3,028,623)	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ (2,975,687)	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,476,303	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ (499,384)	$	48

***(See instructions.)**

Facility Name & ID Number SunBridge Care & Rehab-University # 0042697 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (550,756)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (550,756)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	545,894	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Intercompany Eliminations/Bal Sheet Adjus**	2,481,165	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 3,027,059	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,476,303	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number SunBridge Care & Rehab-University # 0042697 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ (3,144,885)	1
2	Discounts and Allowances for all Levels	43,123	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ (3,101,762)	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	(37,361)	6
7	Oxygen	(44,315)	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ (81,676)	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	(1,510)	13
14	Non-Patient Meals	(962)	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	(24,681)	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	(14,836)	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ (41,989)	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Please see attached Page 19.1	690	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 690	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ (3,224,737)	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	613,714	31
32	Health Care	1,467,838	32
33	General Administration	966,081	33
	B. Capital Expense		
34	Ownership	645,991	34
	C. Ancillary Expense		
35	Special Cost Centers	1,029	35
36	Provider Participation Fee	75,978	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,770,631	40
41	**Income before Income Taxes (line 30 minus line 40)****	545,894	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 545,894	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number SunBridge Care & Rehab-University # 0042697 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	3,646	4,043	$ 87,975	$ 21.76	1
2	Assistant Director of Nursing					2
3	Registered Nurses	5,859	6,231	106,656	17.12	3
4	Licensed Practical Nurses	23,883	25,655	359,660	14.02	4
5	Nurse Aides & Orderlies	55,630	59,225	560,330	9.46	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	3,799	4,096	31,668	7.73	9
10	Activity Assistants					10
11	Social Service Workers	3,179	3,421	36,316	10.62	11
12	Dietician					12
13	Food Service Supervisor	1,766	1,905	22,621	11.87	13
14	Head Cook					14
15	Cook Helpers/Assistants	12,701	13,720	90,176	6.57	15
16	Dishwashers					16
17	Maintenance Workers	1,874	1,978	26,694	13.50	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	6,284	8,112	138,074	17.02	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	4,764	5,354	55,712	10.41	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	123,385	133,740	$ 1,515,882 *	$ 11.33	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	246	$ 8,364	Line 1.3	35
36	Medical Director	$675/Mnth	8,100	Line 9.3	36
37	Medical Records Consultant	$270/Bimnth	3,287	Line 10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	109	6,543	Line 10.3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	117	4,905	Line 12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	472	$ 31,199		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number SunBridge Care & Rehab-University # 0042697 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Jill Henson	Administrator	0.00%	$ 4,200
Richard Klug	Administrator	0.00%	13,744
Kyle Moore	Administrator	0.00%	43,742
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 61,686

B. Administrative - Other

Description	Amount
Management Fee Expense	$ 97,927
Regional Allocation	83,323
TOTAL (agree to Schedule V, line 17, col. 3)	$ 181,250
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Identicard	New employee badges	$ 185
Multipoint National	Real & Pers. Prop. Tax Info	100
Law Off. Of Joseph Bianculli	Legal Fees	2,173
Duane Morris & Heckscher	Legal Fees	23,800
Taliana Kubin & Buckley	Legal Fees	110
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 26,368

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 9,735
Unemployment Compensation Insurance	25,951
FICA Taxes	124,104
Employee Health Insurance	429,165
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Flex Earnings	(168)
Uniform Allowance	45
Hepatitus B Vaccine	1,420
Other Employee Benefits	7,471
Jury Duty/Bereavement Pay	1,571
Home Office Benefits	7,594
TOTAL (agree to Schedule V, line 22, col.8)	$ 606,888

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 150
Advertising: Employee Recruitment	10,164
Health Care Worker Background Check	
(Indicate # of checks performed)	
Bank Service Charges	387
Il Healthcare Association	5,207
Heaton Publications/News Democrat	555
Faulkner & Gray/Channing L Bete Co.	192
Home Office Dues & Subscriptions	199
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 16,854

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	905
Mileage Paid	4,831
Regional Travel	7,830
Home Office Travel	3,776
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 17,342

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number SunBridge Care & Rehab-University # 0042697 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number SunBridge Care & Rehab-University **#** 0042697 **Report Period Beginning:** 1/1/00 **Ending:** 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? If YES, give association name and amount. **Illinois Healthcare Assoc. $5207**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **4,355** Line **10.2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? **XX** YES ____ NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **66,978**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **No** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Arthur Andreson & Co** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Consolidated financials**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.